Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

December 20, 2004

Requestor	Respondent
RS Medical ATTN: ___ P.O. Box 872650 Vancouver, WA 98687-2650	Downs Stanford, PC ATTN: ___ FAX#: (214) 747-2333

RE: Injured Worker:
MDR Tracking #: M2-05-0358-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Anesthesiology and Pain Management, by the American Board of Anesthesiology, licensed by the Texas State Board of Medical Examiners (TSBME) in 1989, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 48 year-old female injured her low back and tailbone area on ___ while unloading a truckload of merchandise. Her diagnosis is lumbar strain/sprain, thoracic myositis/myofascitis, and left sacroiliac joint strain/sprain. She has been treated with medication and therapy.

Requested Service(s)

Proposed purchase of an RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit

Decision

It is determined that there is no medical necessity for the proposed purchase of an RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit to treat this patient's medical condition.

Rationale/Basis for Decision

The patient has been using the RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit stimulator up to 8 hours a day yet still complains of severe low back pain despite using the device. Because of the continued complaint of severe low back pain it is proven the devise is not effective. Therefore the proposed purchase of an RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit is not medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

Director of Medical Assessment

GBS:dm

Attachment

cc: ___, Injured Worker
Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 20th day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0358-01

Information Submitted by Requestor:

- Progress Notes
- Prescriptions
- Denial

Information Submitted by Respondent:

- Progress Notes
- Diagnostic Tests
- Claims